FILED
FEB 24 2003

No. 02-469

In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF OF AMERICAN COUNCIL OF LIFE INSURERS, UNUMPROVIDENT CORPORATION, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Amici will address the following question:

1. Whether the Ninth Circuit erred in holding that an ERISA disability claims administrator's determination of disability is subject to the "treating physician rule" and, therefore, the claims administrator is required to accept a treating physician's opinion of disability as controlling unless the claims administrator rebuts that opinion in writing based on substantial evidence in the record?

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INTEREST OF THE *AMICI CURIAE*[1]

The American Council of Life Insurers ("ACLI")

ACLI, a non-profit trade association, is the largest trade association in the United States representing the life insurance industry. The ACLI's members include the 383 legal reserve life insurers, accounting for 70 percent of life insurance premiums in the United States. ACLI advocates the interests of its members before federal and state legislators, state insurance departments, federal regulatory agencies, and the courts. ACLI files this Brief to communicate and support the concerns and interests of its members that handle disability claims for employers. In particular, it shares the concerns of UNUMProvident Corp. as set forth in detail below.

The Health Insurance Association of America ("HIAA")

HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA develops and advocates federal and state policies that build upon the health care system's quality, affordability, accessibility and responsiveness. HIAA's member companies that are engaged in the disability

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[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this Brief *amici curiae*. Their letters of consent have been filed with the Clerk of the Court.

Pursuant to Rule 37.6 of the Rules of this Court, *Amici* state that this brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *Amici*, made a monetary contribution for the preparation or submission of this brief.

income insurance marketplace, share the concerns detailed below by UNUMProvident Corp.

UNUMProvident Corp.

UNUMProvident Corp. is the parent holding company of UNUM Life Insurance Company of America, The Paul Revere Life Insurance Company, and Provident Life and Accident Insurance Company (collectively, the "UNUMProvident Companies"). The UNUMProvident Companies are three of the largest disability insurance carriers in the United States. They are authorized to issue individual and group disability policies in all 50 States. Many of these policies fund disability benefits under employee welfare benefit plans regulated by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

The UNUMProvident Companies collectively receive approximately 400,000 new disability claims each year. Last year alone, the UNUMProvident Companies paid approximately 3.6 billion dollars in disability benefits and provided assistance to approximately 500,000 individuals and families. The UNUMProvident Companies sell their policies and services to employers who wish to allocate their scarce resources to providing an efficient and consistent plan for making available disability benefits and return to work services for their employees.

In order to accomplish this goal, the UNUMProvident Companies directly employ approximately 100 physicians and 350 nurse care managers and vocational rehabilitation specialists. In addition, the UNUMProvident Companies draw upon approximately 1,000 nurses and vocational rehabilitation specialists of a separate UNUMProvident subsidiary, for field-based case management and rehabilitation services. In 2002, the UNUMProvident Companies

spent $60 million for medically related services. The UNUMProvident Companies also employ "impairment based" claims processes with separate units handling discrete medical specialties such as cancer, cardiac and orthopedics. This process allows the UNUMProvident Companies to better leverage their base of knowledge and resources.

The UNUMProvident Companies go to these lengths to achieve accurate, fair and consistent determinations across the country. Brokers and consultants recommend the UNUMProvident Companies to their employers based on the UNUMProvident Companies' reputation for fairness and their specialized expertise. Without accurate, fair and consistent decision-making, the UNUMProvident Companies' customers (22% of the Fortune 500 and approximately one out of every four companies in North America) would no longer choose the UNUMProvident Companies as their disability carrier. To succeed in the marketplace, the UNUMProvident Companies thus face the challenge of minimizing the costs of their products, while ensuring that benefit determinations are made in accordance with the requirements of ERISA and achieve the goals of accuracy, fairness and consistency.

The UNUMProvident Companies have strived to meet those goals within the current ERISA framework. Of the approximately 400,000 new disability claims filed in 2001, approximately 90% were paid. Of the remaining claimants, approximately one-half were no longer claiming benefits when payments would have begun, roughly 2% were determined **not** to be disabled, and the remainder were denied benefits for reasons irrespective of whether they were disabled or not (*e.g.*, policy exclusions, etc.). At the end of the day, less than ½ of 1% of claimants resort to lawsuits. There is no reason to believe that these statistics are unique throughout the industry.

In short, whether the insurer is one of the UNUM-Provident Companies or one of ACLI's or HIAA's members, the fact is that the claims that reach the courts, including the rare and occasional claim that plaintiffs' counsel hype as evidence of unfair practices, represent a miniscule portion of the huge volume of claims made under the policies issued. Courts resolve those claims under ERISA by insuring that the challenged decisions are not arbitrary, and try to do this in a speedy and cost-effective manner that minimizes the very substantial costs of litigation that would otherwise be borne, ultimately, by employers. Year in and year out, employers have tended to find that this current regime under ERISA provides a benefit to their employees sufficient to induce more and more employers to commit the resources necessary to fund the policies. And each year more and more employees and unions find that the plans offer sufficient value so as to be seen as a form of significant compensation. The UNUMProvident Companies themselves, and on behalf of their customers, and ACLI and HIAA on behalf of their members and their customers, thus possess strong interests in ensuring that Congress's brilliant creation known as ERISA does not lose the genius of its balance between minimizing costs and maximizing benefits for employees.

The rule applied by the Ninth Circuit disrupts this balance and signals a slide down the slope of increased costs and litigation, as explained below in detail. Because these consequences would injure employers, employees and insurers throughout the Nation, the UNUMProvident companies, ACLI, and HIAA submit this Brief to assist the Court in the resolution of this case.

SUMMARY OF ARGUMENT

Under prevailing interpretations of Congressional intent, employers have the ability to set up disability benefit plans under which a claims administrator is given broad discretion to determine whether a beneficiary is eligible for benefits. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-111 (1989). This discretion, of necessity, includes the ability to weigh conflicting evidence. Until now, this regime has successfully promoted Congress' intent of creating fair and efficient claims settlement procedures and encouraging the formation of benefits plans.

The Ninth Circuit has now turned this regime on its head. On the basis of demonstrably flawed stereotypes, the Ninth Circuit has granted to so-called treating physicians a presumptive authority over the decisions of claims administrators. In fact, the Court of Appeals went a step further by holding that a claims administrator's exercise of his discretion to weigh evidence constituted a conflict of interest resulting in the forfeiture of that very discretion. This rule and its circular application deprives claims administrators of the ability to make nuanced, fact-sensitive judgements without greatly increasing administrative costs. Identical benefits claims would no longer depend on uniform medical standards, but rather on which "treating physician" is selected. And it paves the way for courts to end-run claims administrators' discretion by mandating deference to any evidence the court thinks is more credible. Adoption of the rule would increase both administrative and litigation costs, thereby unduly discouraging employers from offering welfare benefit plans.

This Court should reverse.

ARGUMENT

I. THE TREATING PHYSICIAN RUBRIC CONCEALS A FACT-SENSITIVE DIVERSITY OF RELATIONSHIPS AND CIRCUMSTANCES THAT DEFY A ONE-SIZE-FITS-ALL RULE.

The Ninth Circuit premised its decision in *Regula* (upon which the Court of Appeals relied in this case) on the notion that adoption of the "treating physician rule" will lead to more accurate decision-making. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). This belief is premised on the notion that the so-called "treating physician" is entitled to special deference because she "is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Id.* at 1139.

The Ninth Circuit apparently presumes that the "treating physician" is a single known entity, a common factor in every case, warranting a common and heavy presumption of correctness. The Ninth Circuit seems to presume, further, that the opinions of so-called treating physicians, with a high degree of uniformity, are based on information that only they possess, are within their expertise, are based on nationally uniform standards, and are unaffected by undue deference to self-reported symptoms that are not consistent with the objective medical evidence. Such presumptions form the presumed basis for a "one-size-fits-all" rule to be applied in all ERISA cases involving disabilities.

These presumptions have been adopted without any evidence of investigation, rule-making proceedings, or even careful analysis. In practice, these presumptions are the product of stereotypical thinking that entirely overlooks the diverse, fact-sensitive situations confronted by claims administrators day in and day out. A claims administrator who reads the Ninth Circuit opinions cannot even

tell what a treating physician is, when, exactly the treating physician's opinions are due deference, or what types of "substantial evidence" need be relied upon to rule otherwise (other than that a contrary opinion by a qualified examining doctor is not enough).

As is often the case with broad-brush pronouncements based on stereotypes, the Ninth Circuit's treating physician rule fits poorly with the variety of actual circumstances presented by the real world.

A. The Nature Of The Claims Process Requires Case-By-Case Exercise Of Discretion.

The disability claim process is typically initiated by a contact from the claimant, requesting the necessary application forms. These forms frequently include a statement by the claimant (including background information regarding employment, coverage under the policy, alleged disability, and medical treatment information); a statement by the claimant's employer (including job description and earnings information); and a statement by the claimant's treating doctor (including treatment information, diagnosis, prognosis, restrictions and limitations). If medical records are not submitted with the claim forms, claims administrators typically request records from the claimant's physician(s). Claims administrators may also request further information from the employer regarding job duties.

Once the medical information is received, it is frequently referred to in-house medical departments for evaluation. Medical departments typically consider several factors such as whether the records actually support the conclusions in the initial claim forms and, ultimately, whether the records support the restrictions and limitations alleged in support of the claim. This portion of the claim review process may result in one or more of a number

of responses from the medical department. For example, the medical department may conclude that the information submitted is sufficient to demonstrate a disability or it may conclude that the information on its face demonstrates that the claimant is not disabled. On the other hand, the medical department may recommend that claims personnel obtain additional information or clarification of discrepancies in the records. The medical department may also recommend an independent medical examination or a functional capacity examination. The latter test is designed to measure the claimant's specific medical restrictions and limitations to determine the types of occupations the claimant is capable of performing.

Where vocational information is obtained or submitted, the claims administrator may also seek advice from trained vocational and rehabilitation personnel in appropriate cases. The purpose of these reviews is to determine the exact requirements of the claimant's occupation. Where disability benefits are paid based on whether the claimant can perform the material duties of any occupation, other tests/studies may be performed, such as a transferable skills analysis (to determine whether the claimant's education and job skills can be translated into other occupations) and/or a labor market survey (to determine whether there are available jobs in a given geographical market).

Once all of the information is gathered and analyzed, claims administrators determine whether the claimant is entitled to benefits under the terms of the benefit plan. Each claim stands on its own merits. This necessarily means that some claims may be determined based on a small amount of information whereas other claims require a substantial amount of information. The point is that each and every claim must be decided independently of each and every other claim with claims administrators balancing the information in each specific claim file. Once

a decision is rendered, the claimant is notified in writing in accordance with the requirements of ERISA, section 503 and accompanying DOL claim procedure regulations.

ERISA permits a claimant whose claim is denied in whole or in part at least one appeal. When a claimant provides notice of his request for an appeal, the matter is reviewed from scratch, with referrals to medical and/or vocational experts as appropriate. Additional information is sometimes submitted by the claimant or obtained by the claims administrator on appeal. After thorough review, the claims administrator issues a written notice to the claimant, explaining its decision and either overturning or affirming the initial denial.

In summary, the claim review process is a deliberate, detailed, thorough, process. The process is also flexible and is tailored to the particular circumstances of a given claim. Information from the treating physician is seriously considered and in some cases may be the only information necessary to determine whether benefits are payable. In other cases, the treating physician's opinion may only be a fraction of the information relevant to the claim. In all cases, the claims administrator must consider all of the relevant evidence before rendering a decision on a particular claim.

B. The Existing Legal Regime Under ERISA Appropriately Allows The Administrator To Exercise Discretion Based On The Particular Facts Of Each Claim.

Prior to the Ninth Circuit's ruling in *Regula*, circuit courts, including the Ninth Circuit, followed this Court's mandate in *Firestone* by holding that where plan documents expressly grant discretion, the proper exercise of that discretion includes the function to weigh conflicting evidence. *See Firestone*, 489 U.S. at 110-111. *See also e.g.*,

Vlass v. Raytheon Employees Disability Trust, 244 F.3d 27, 32 (1st Cir. 2001); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 (8th Cir. 2001); *Threadgill v. Prudential Securities Group, Inc.*, 145 F.3d 286, 295 (5th Cir. 1998); *Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996); *Abnathya v. Hoffman LaRoche, Inc.*, 2 F.3d 40, 45 (3rd Cir. 1993); *Pratt v. Petroleum Prod. Mng. Inc. Employee Sav. Plan & Trust*, 920 F.2d 651, 658 (10th Cir. 1990). Obviously, this includes the ability to weigh conflicting medical evidence. *See Leahy v. Raytheon Co.*, 315 F.3d 11, 19 (1st Cir. 2002) ("Indeed, when the medical evidence is sharply conflicted, the deference due to the claims administrator's determination may be especially great."). Accordingly, decisions about how much weight to give so-called "treating physicians" were made on a case-by-case basis.

Depending on those variations, many benefits denials were upheld despite the existence of evidence supporting disability from treating physicians. *See Vlass*, 244 F.3d at 30-32 (upholding judgment for defendant even though treating physician's reports supported finding of disability); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 186-87 (1st Cir. 1998) (reversing judgment for plaintiff notwithstanding treating physician's opinion that plaintiff was disabled). Depending on those variations, and without reliance on any hard and fast rule, some determinations rejecting treating physicians' opinions were overturned. *See Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (rejecting treating physician rule but holding that fact-specific weighing of all medical evidence could not support denial of benefits).

In adopting a deferential standard, the hallmark of which is the claims administrator's ability to weigh evidence where plan documents gave him the discretion to do so, the circuits were not only following *Firestone*, but also the legislative purposes underlying ERISA and sound

public policy. While this Court in *Firestone* rejected a deferential standard in the absence of discretionary language, it expressly stressed that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review." 489 U.S. at 115.

Allowing claims administrators to exercise discretion, when the parties have expressly contracted for it, is directly consistent with Congress' concern "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (stating that ERISA's remedial scheme represents "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans."). *See also Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993) ("a primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.").

These flexible standards have been effective for employees. Until now, this Court's decision to delegate the function of weighing competing evidence to claims administrators has resulted in fulfillment of Congress' objective to "promote the interests of employees and their beneficiaries." *See Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

The rule adopted by the Ninth Circuit threatens to upset this flexible and successful legal landscape with a broad-brush rule based on erroneous stereotypes. As we explain in greater detail below, the close cases that give rise to hard decisions present an array of fact-sensitive

judgment calls that defy the sensible application of any broad-brush rule.

C. Fair Consideration Of The Facts Of Each Claim Defies A Broad-Brush Rule.

1. The Nature And Duration Of The Doctor-Patient Relationship Varies Greatly.

The Ninth Circuit stated that "treating physicians" "have a greater opportunity to know and observe the patient . . . " *Regula*, 266 F.3d at 1139. Depending on what the Ninth Circuit means by the term "treating physician," this is not necessarily true. A physician's opinion may be formed after only one visit, which may or may not even include a detailed examination. Certainly, it is not uncommon for patients to bring their disability insurance forms with them on their first visit to a specialist. In such instances, the "treating physician" differs from the examining physician only in that he offers a course or plan of treatment. He has no superior knowledge.

So where, then does one draw the line? Are two visits enough? And what if, as in this particular case, the doctor with the long-standing patient relationship, such as an internist, is relying on a consult from a specialist, and it is the specialist's opinion that is more relevant? *See Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 826 (9th Cir. 2002). Is the internist's opinion the opinion of a treating physician?

The answer is that in some cases the claims administrator will be inclined to place great weight on the internist's opinion, while in others it will not. It depends on the specific facts, the nature of the impairment, the quality of the opinion, whether the opinion comports with the symptoms, and so on.

2. The Expertise And Abilities Of The Doctors Varies Greatly.

Even putting to one side the extent of exposure to the patient that a doctor has had, one treating physician is not always like another. A dermatologist's opinion regarding the level of impairment caused by a brain tumor is usually entitled to little increased weight or deference. *See Regula*, 266 F.3d at 1153 (Brunetti, J., dissenting) (noting that denial letter explained that Committee found the reviewing-doctor's opinions more persuasive and expressed concerns about the "treating doctor's" lack of objectivity based on comments she made outside her area of expertise). But under the rule adopted by the Court of Appeals, claims administrators must accept that opinion or devote much time and expense developing "clear and convincing evidence" to rebut it.

3. The Amenability Of The Symptoms To Objective Analysis Varies Greatly.

With many conditions, opinions of impairment are predicated on subjective self-reporting of the claimant. Some of these conditions are themselves highly controversial in medical circles. *See* Bohr, T., *Fibromyalgia Syndrome and Myofascial Pain Syndrome, Do They Exist?*, Neurologic Clinics, Volume 13, Number 2, May 1995.

With elusive disorders of this sort, the very existence of the disability plan becomes a factor. Patients may be able to work with discomfort, but some would prefer not to do so. Confronted with such a situation, particularly one involving issues of stress and pain, the doctor may well conclude that, although he would not preclude work if the patient needs the income, he can support a claimed inability to work if the result is that the patient still gets income, and feels better. Helping the patient feel better is the doctor's job.

Indeed, in order to maintain an effective doctor/patient relationship, treating physicians must essentially accept their patients' complaints at face value, rather than seek to question or test them through independent analysis. *See Maniatty v. UNUMProvident Corp.*, 218 F.Supp. 2d 500, 504 (S.D.N.Y. 2002) ("[I]t was not unreasonable for the administrator to conclude that the only material reason the treating physicians were reaching their diagnoses was based on their acceptance of plaintiff's subjective complaints: *an acceptance more or less required of treating physicians*, but by no means required of the administrator.") (emphasis added). In these circumstances, a rule that requires deference to the treating physician's opinion is a rule that, in effect, requires deference to the claimant's stated opinion.

Mental disorders present their own peculiar problems in this regard. Although objective criteria may exist with respect to the *diagnosis* of mental disorders (*i.e.*, Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM IV)), there are almost no such criteria designed to guide the assessment of occupational disability resulting from mental disorders. Treating practitioners frequently make disability assessments after brief initial interviews based almost exclusively on subjective reports of patients. And the treating doctor, by his very role, is often reluctant to challenge what the patient tells him. In fact, disbelief or skepticism by the doctor would impede the psychotherapeutic relationship, which is based in large part on trust. While a favorable opinion concerning disability will ensure another visit, an unfavorable opinion will most likely mark the end of the relationship.

A prudent claims administrator is aware of these real world factors. He therefore will consider, in questionable cases, seeking an independent opinion. He will look at factors such as, for example, whether the claimant appeared to have motives to want to work, or not to want to

work. A broad-brush rule that the favorable opinions of claimant's chosen practitioner must be given a burden shifting weight eliminates careful consideration of this type.

4. The Absence Or Presence Of Indicia Of Doctor-Bias Varies Greatly.

Many treating physicians call it straight even if they risk losing the patient. Others do not, for reasons that are not necessarily improper. A physician committed to curing the patient must consider the patient's best interests. *See* Dickman, R., *Bending the Rules to Get a Medication*, American Family Physician, Volume 61, Number 5, March 1, 2000, p. 2 ("The nature of the 'engagement with a patient' enjoins us to do everything we can to preserve or restore his or her health."). A physician may determine that although able to work, the patient's interest are better served by staying out of work and collecting disability, than by returning to a job the patient may well dislike. *See id.* ("When I acknowledge the special relationship I have with my patient, my openness to bending the truth in order to serve her direct interest is enhanced . . . "); Bigos, S.J., Battie, M.C., Spengler, D.M., et al.: *A Prospective Study of Work Perceptions and Social Factors Affecting the Report of Back Injury*, Spine, 16:1, 1991 (pre-existing job dissatisfaction is a predictor for disability). Disability determinations based on such considerations clearly take place. A recent study shows that 28% of physicians surveyed agreed with the statement that "in general it is ethical to 'game the system' for your patient's benefit." Wynia, M., Cummins, D., VanGeest, J., Wilson, I., *Physician Manipulation of Reimbursement Rules for Patients*, Journal of the American Medical Association, April 12, 2000, Vol. 283, No. 14, p. 1858. *See id.* at 1865 ("While insurance policies are contracts between patients and

insurers, our findings suggest that some physicians believe that strictly enforcing these contracts is contrary to their professional role as patients' agents and caregivers.") And this problem is exacerbated when a claims administrator has no direct way to know whether or not the physician in question is one of the 28% who believe that such tactics are acceptable.

Such physician bias is also sometimes evidenced by the timing and circumstances of the physician's retention. Many times patients visit doctor after doctor until they find one that will validate their complaints. *See* Bohr, *Fibromyalgia Syndrome and Myofascial Pain Syndrome, Do They Exist?*, *supra* at p. 380 (*citing* Fibromyalgia newsletter which urges sufferers to "avoid relationships with practitioners and physicians who cause you to doubt yourself. . . . If things don't work out, fire them and hire someone else more suited to your needs" and provides list of suggested practitioners); Aranoff, G., Feldman, J., Campion, T., *Management of Chronic Pain and Control of Long-Term Disability*, Occupational Medicine, Vol. 15, No. 4, October – December 2000, p. 759 ("Feeling disbelieved or discounted, [chronic pain] patients often go from one physician to the next looking for the one who 'will really listen and understand my pain.'").

A doctor retained after a disability claim has been made, or even after the initial claim has been denied, may be selected for her specialized expertise, or she may be selected because the claimant or his attorney understand that she is more likely to render a more favorable disability determination than her predecessors. Opinions of doctors selected for the purpose of supporting the diagnosis, or worse yet the disability claim, are entitled to less, not more weight.

The physician's association with claimant's counsel is also a factor in assessing bias. In *Regula*, the majority

found "far more troubling . . . the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts." 266 F.3d at 1143. This is an odd comment indeed. If a plan hires the same neurologist to review claims of back pain, and that neurologist applies consistent, medically-recognized standards causing him to find 90% of the claimants disabled, how is that troubling? On the other hand, what of the claimants' counsel who refers his clients to his chosen "treating physician" who finds the claimants almost always disabled and prescribes continuing treatment? The Ninth Circuit has ruled that, in all cases, an opinion from the latter must be met by "substantial evidence," and that a contrary opinion from the former will not suffice.

5. The Pertinence Of The Doctor's Knowledge To The Disability Issue At Hand Varies Greatly.

A physician otherwise perfectly qualified to diagnose a particular condition may not have inquired about what the claimant's job duties entail, let alone seek input from the employer. Likewise, such a physician may have no expertise or experience in determining how a particular sickness or injury impacts one's ability to perform those duties, relying instead on his instincts and the subjective reports of his patient. Yet that same physician may be totally willing to render an opinion on that topic at the request of his patient. Disability insurers frequently receive such opinions, and sometimes decide, depending on the circumstances, to defer to the competing view of their own qualified and experienced practitioner.

In sum, the significance and value brought to the table by a so-called "treating physician" varies depending on the circumstances of each case. Very often claims administrators do find the opinion of a treating physician to be very significant in making accurate disability determinations. The

courts, of course, rarely see these cases. Sometimes, though, especially in the close, disputed cases, the opinion of the so-called treating physician is not something that is persuasive to an experienced claims administrator.

II. THE NINTH CIRCUIT'S RULE WILL DECREASE CONSISTENCY AND UNIFORMITY IN BENEFIT DETERMINATIONS.

Employers expect benefit determinations to be consistent, such that one similarly situated employee is treated like another. Claims administrators achieve this consistency by selecting skilled medical professionals, who can review a large number of similar claims, develop expertise in matching conditions to work demands, and form consistent views over time. These professionals are also involved in assisting claimants with back-to-work programs, thus developing a sense of what people with certain conditions can and cannot do, and what accommodations can be made to allow them to work.

To adopt a rule that the opinions of so-called treating physicians must be deferred to, even in the face of a contrary medical opinion, will threaten claims administrators' ability to achieve consistent treatment of like cases. Benefits in cases involving subjective claims will turn, instead, on doctor-shopping by claimants. Consistency will decrease, costs will rise, and fewer employers will provide benefits great enough to tempt workers to look for ways to avoid having to return to work, harming those who truly cannot return.

Assessing the credibility of medical evidence on a case-by-case basis is reasonable, leads to consistent results for similar claims and has worked to the benefit of millions of employees since the enactment of ERISA. There is no reason to change the rule now.

III. THE "OPPORTUNITY" TO EXPLAIN AND REBUT THE TREATING PHYSICIAN'S OPINION DOES NOT SAVE THE RULE.

One possible response to the foregoing critique of the so-called treating physician rule is that the Ninth Circuit has not in fact held that the claims administrator must accept the position of the treating physician in all cases. Rather, the Ninth Circuit has left the door ajar, describing the so-called treating physician rule as one under which the claims administrator may reject the opinion of the treating physician if, and only if, the claims administrator gives "specific legitimate reasons for doing so that are based on substantial evidence in the record." *Regula*, 266 F.3d at 1140. Thus, perhaps "all" the Ninth Circuit has done is to construe its application of the treating physician rule as shifting to the claims administrator a "mere" burden of articulating why the claims administrator decided not to accept the opinion of the treating physician.

Such a defense of the treating physician rule in ERISA cases fails for three reasons.

A. The Rule's Presumption In Favor Of The Treating Physician Is Substantial.

First, as articulated by the Ninth Circuit, the rule in fact creates far more than a "mere" burden of explanation. Once the claims administrator believes that he has received an opinion from a doctor that might be deemed to qualify as an opinion of a treating physician, the claims administrator will have to pay for and obtain a second medical opinion unless he can offer "clear and convincing" evidence, in writing. *Regula*, 266 F.3d at 1140. Moreover, once the claims administrator obtains a second medical opinion, and even if the second medical opinion is directly contrary to that of the so-called treating physician, the claims administrator must follow the opinion of the

treating physician unless the claims administrator can "show by substantial evidence in writing why the opinion of the treating physician must be rejected." *Id.* The rule thus imposes, at a minimum, a burden to both explain and to rebut with something more than a competing medical opinion by a qualified doctor known to the administrator. The rule thus elevates the treating physician's opinion to a weighty presumption.

The weight of this presumption appears to be very substantial. In this case, the key issue was subjective, the medical condition on its face was amenable to workplace accommodation and/or medication, the administrator received a firm opinion from a qualified neurologist, the administrator offered the claimant two opportunities to have his physicians critique the independent examiner's opinion, and the claimant, who was represented by counsel, failed to do so. *See* App. to Petition for Certiorari, p. 34. Yet the Ninth Circuit concluded, as a matter of law, that such was a mere "scintilla" of evidence insufficient to outweigh the original opinions of the claimant's chosen, suddenly-mum doctors. *Nord*, 296 F.3d at 832. Under this rule, no adult with common degenerative disc disease who does not want to work, even at a sedentary job that allows frequent standing and stretching, ever need do so again as long as his or her employer establishes a disability plan with generous income replacement benefits. And if that is the result, fewer employers will sponsor and pay for such plans, harming the huge majority of disabled workers who are now able to obtain benefits. The Ninth Circuit's broad-brush distrust of claims administrators thus becomes the enemy of the great good Congress has wrought.

B. Deciding When The Rule Applies Will Spawn Collateral Litigation.

Second, no matter how one describes the treating physician rule, and even if one were to pretend that it simply shifts the burden of explanation, one still has to deal with resolving the definitional complexity of deciding when the rule applies. Must the physician upon whom the claimant relies have actually examined him? For how long must he have treated him? Does the burden to explain and rebut arise if the putative treating physician was retained by the claimant's counsel? What if the treating physician is actually opining on a matter of work demands or if the opinion rests on a simple subjective recitation of the claimant's self-reported symptoms? If the doctor is opining outside of his specialty, does the rule apply? Does the claims administrator have to explain why the rule does not apply (which would mean, apparently, that mere incantation of the rule by a claimant, whether applicable or not, would shift to the claims administrator a burden of explanation)? It will, at a minimum, impose a new burden of detailed explanation upon claims administrators and a substantive and substantial burden of persuasion as well.

C. The Rule Opens The Door For Courts To Apply More Presumptions To Other Kinds Of Evidence.

The logic behind such a burden-shifting rule leads down a long and expensive slope. If the Ninth Circuit distrusts independent doctors retained by claims administrators, then what will it next have to say about weighing the probative force of, for example, vocational evaluations submitted by claimants against those that are put forward by the employer? Will the claimant's substance abuse counselor trump a psychologist retained by the plan? Is a

neighbor's observations of apparent pain by the claimant more credible than that of the employer?

The facts of this case provide a preview of this slippery slope. The Ninth Circuit held that Black & Decker's rejection of the hypothetical conclusion of its own human resources representative, was "not only high-handed but also certainly some evidence of a conflict." *Nord*, 296 F.3d at 830. And this was despite the fact that, as noted by the District Court, the human resources representative "apparently lack[ed] any expertise or credentials in medicine, disability evaluation, and vocational evaluation," and "did not take into account plaintiff's prescription painkillers." Appendix to Petition for Certiorari, p. 34.

Under the new regime established by the Ninth Circuit, then, fact-sensitive, discretionary reviews will be replaced by literally years of litigation as courts seek to write out the full panoply of subsidiary rules to go with this new regulation.

IV. THIS CASE DOES NOT PROVIDE AN OPPORTUNITY TO REVISIT *FIRESTONE* BUT IF THIS COURT DOES SO IT SHOULD HOLD THAT THE NINTH CIRCUIT ERRED IN ITS INTERPRETATION OF THAT CASE.

The intrinsically related issues of "discretion" and "conflict of interest" present somewhat of a conundrum in this case. On the one hand, by requiring administrators to defer to "treating physicians," by applying a "presumptively void" conflict of interest test, and by holding that failure to follow the treating physician rule was evidence of conflict, the Court of Appeals voided the administrator's discretion entirely. In the abstract, then, the Court of Appeals' analysis invites an examination of *Firestone* and what this Court meant when it stated that a conflict of interest "must be weighed as a factor" in determining

whether the administrator abused his discretion. *See* 489 U.S. at 103.

On the other hand, this Court has not granted *certiorari* on the "conflict of interest" issue. Moreover, although the Ninth Circuit used a "conflict of interest" analysis to apply *de novo* review, the court did not remand in order for the district court to conduct such a *de novo* review. Instead, it held that "no reasonable trier of fact could conclude that Nord is not disabled." *Id.* Were that indeed the case, then the result would be the same irrespective of the standard of review. Thus, everything that the Ninth Circuit says in its opinion about the standard of review, and "conflict of interest," is irrelevant to its holding. Moreover, if this Court reverses the Ninth Circuit's application of the treating physician rule, then the principal asserted basis for finding a conflict of interest (failure to follow the treating physician rule) disappears.

Accordingly, based on the issue upon which this Court granted *certiorari*, and based on the ultimate holding by the Court of Appeals, the proper result is to maintain *Firestone* as a given and treat the "conflict of interest" issue as not properly raised. This Court should simply reverse the Court of Appeals' adoption of the treating physician rule and remand for further proceedings. In the event, nevertheless, that this Court chooses to examine the Ninth Circuit's interpretation of *Firestone*, it is clear that the interpretation is erroneous for the reasons set forth below.

A. The Court Of Appeals Impermissibly Eviscerated The Claims Administrator's Discretionary Right To Independently Weigh The Medical Evidence.

Despite the well-settled and firmly grounded legal landscape described above, whereby decisions concerning

the amount of weight to give medical evidence were made by claims administrators on a case-by-case basis, and without citing any evidence to the effect that this mode of analysis somehow failed to protect ERISA beneficiaries sufficiently, the Ninth Circuit has now dramatically changed the legal lay of the land.

By purporting to require administrators to weigh medical evidence in a compulsory manner in all cases involving so-called "treating physicians," the Court of Appeals' ruling eliminates the very discretion that the *Firestone* Court expressly held could be contracted by the parties through plan documents. 489 U.S. at 114. As explained above, with discretion comes the right to determine the credibility of evidence. The Ninth Circuit now purports to tell claims administrators how to perform that function, and where "treating physicians" are concerned, has strictly limited that right. This is contrary to *Firestone*.

B. The "Presumptively Void" Test Applied By The Court Of Appeals Is Invalid.

In *Firestone*, this Court held that "if a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115. Since *Firestone*, the circuits have split in their interpretations of this language in the context of the proper standard to apply when the decision-maker is also the funding source. *See* Comment, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Applied in an ERISA Action With an Emphasis On The Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 827-28 (1999).

The majority of circuits apply differing variations of a "sliding scale" test whereby courts adhere to the abuse of discretion standard but temper the amount of deference according to the degree of conflict under which the courts perceive the administrator to be operating. *See id.* at 832. The Ninth Circuit is among the minority of two circuits that apply a "presumptively void" test. *See id.* at 853-57. Under this test, a "heightened standard" applies where the decision-maker is also the funding source. *Id.* Under the heightened standard, if the claimant comes forth with "material, probative evidence" tending to show that the administrator's self-interest caused it to breach its fiduciary duty to the claimant, the burden shifts to the administrator to show that the conflict did not affect its decision. *Id.* at 857. If the administrator cannot rebut this presumption, it forfeits any discretion and the court reviews the decision *de novo*. *Id.*

There is, however, no reason to afford less deference or apply a "heightened standard" simply because the decision-maker is also the source of funds. In *Firestone*, the Third Circuit held that such an "inherently conflicted" fiduciary is not entitled to deference solely because the court viewed such a conflict as providing a disincentive for impartial decision-making. 828 F.2d 134 (3rd Cir. 1987) *aff'd in part and rev'd in part*, 489 U.S. 101. This Court rejected that rationale stating that "we do not rest our decision on the concern for impartiality that guided the Court of Appeals . . . " that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review . . . " and that "if a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as *a factor in determining whether there is an abuse of discretion*." 489 U.S. at 115 (emphasis added).

Moreover, ERISA specifically allows an employer to appoint its own officers to administer its plans even if the company is a party in interest. 29 U.S.C. § 1108(c)(3). *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (stating that Congress would have prohibited corporate officers from serving as claims administrators if it questions the ability of such persons to administer employer-created plans fairly). *See also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1997) stating that Congress "expect[ed] that the courts will interpret [ERISA's] (. . . fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans" and that while trust law may provide a "starting point" "courts may have to take account of competing congressional purposes" such as encouraging the formation of benefit plans). *Id.* at 497.

Finally, the marketplace itself provides substantial competing incentives for administrators to decide claims accurately. Simply put, employers cannot attract good employees and insurers cannot sell policies, if it is perceived that the benefits promised are illusory. *See Leahy*, 315 F.3d at 17 ("the structure of the Plan furnishes an incentive for MetLife to be unbiased in its handling of claims. This is telling, for courts should not lightly presume that a plan administrator is willing to cut off its nose to spite its face."); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) ("Travelers can hardly sell policies if it is too severe in administering them); *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981 (7th Cir. 1999) (Employers "offer fringe benefits such as disability plans in order to attract good workers, which they will be unable to do if promised benefits are not paid."). The UNUMProvident Companies' claims statistics (*supra*, p. 3) overwhelmingly demonstrate that there is no support for the notion that their staff is "any more 'partial' against applicants than are federal judges when deciding income tax cases." *See Perlman*, 195 F.3d at 983.

In sum, the mere fact of a so-called "inherent conflict" cannot serve to change the applicable deferential standard. The Ninth Circuit's "presumptively void" test presumes that Congress and this Court intended to limit the discretion of an employer like Black & Decker because it is likely to deny claims to protect its bottom line. These presumptions are all invalid and therefore so is the Ninth Circuit's test.

C. The Court Of Appeals' Holding That Failure To Follow The Treating Physician Rule Is Evidence Of A Conflict Constitutes A Circular Attempt To Get Around The Required Deferential Standard Of Review.

By holding that failure to apply the treating physician rule is material, probative evidence of a conflict of interest, the Court of Appeals collapsed the inquiry as to whether the claims administrator abused his discretion, with the inquiry as to whether the claims administrator should have any discretion at all. This was a clever, but circular and invalid end-run around the deferential standard mandated by *Firestone*.[2]

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[2] *Amici* are unaware of any circuit court that has held that simply by failing to grant deference to the opinion of a "treating physician," an administrator forfeits the discretion granted to it by the plan documents. In fact, at least three circuits have held that reliance on independent medical opinions (contrary to those of "treating doctors") removed any alleged taint of "conflict" thereby supporting review under a deferential standard. *Leahy v. Raytheon Co.*, 315 F.3d 15, 16 and n.4 (1st Cir. 2002) ("We are aware of no case holding that a plan administrator operates under a conflict of interest simply by securing independent medical advice . . . extrapolating from the available case law suggests the opposite conclusion."); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997) (any conflict of interest "greatly mitigated" by reliance on independent roundtable); *Donato v. Metropolitan Life Ins.*

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Essentially, the court was able to obviate the abuse of discretion standard simply by substituting its own judgment for that of the claims administrator (which under an abuse of discretion standard, it cannot do). First, the court found a particular piece of evidence (treating physicians' opinions) more credible (*i.e.*, substituted its judgment for that of the administrator). Then, it created a presumption of taint by holding that failure to defer to that evidence signified a conflict of interest. The administrator, of course, could not rebut the presumption, nor could any administrator, having in the first instance failed to explain the reasons for not deferring. And thus, any discretion fell away, the standard of review was converted to *de novo*, and now the court was free to substitute its judgment for that of the administrator, deciding as a factual matter that the claimant was disabled (though purporting to use the summary judgment standard as a way to decide the issue itself rather than remanding to the district court).

The Court of Appeals thus paved the way for reviewing courts (whether district courts or courts of appeals) to entirely obviate the administrator's discretion any time they disagree with the manner in which the administrator exercised that discretion. And it does not stop with "treating physicians." As discussed above, if failing to defer to a treating physician is evidence of conflict, what prevents courts from holding that failing to defer to any other equally relevant piece of evidence also constitutes a conflict? That is exactly what the Court of Appeals did

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Co., 19 F.3d 375, 380, n.3 (7th Cir. 1994) (insurer's reliance on advice of independent physician rebutted any potential conflict). *Leahy*, in particular, is interesting because the First Circuit declined to adopt the treating physician rule even though one member of the unanimous panel, Judge Fletcher (sitting by designation), was the author of both *Regula* and *Nord*. *See* 315 F.3d at 20.

here by holding that rejection of the human resource representative's opinion was "high handed . . . [and] also certainly some evidence of a conflict." 296 F.3d at 830. Thus, again, the court stepped into the shoes of the claims administrator, decided which evidence was more credible, and used the administrator's contrary view on credibility (*i.e.*, the administrator's exercise of its discretion) to rob it of that very discretion granted by the plan documents and mandated by *Firestone*.

At the end of the day, the result here was that the claims administrator lost the discretion granted to him by the plan documents for no other reason than that the Ninth Circuit is unwilling to rely on an employer who voluntarily establishes a plan to administer it fairly. But again, as discussed above, such a result is contrary to *Firestone*, Congressional intent, and sound public policy.

To be sure, this Court has held that a conflict of interest must be "weighed as a factor in determining whether there is an abuse of discretion." *Firestone*, 489 U.S. at 115. While this phrase has caused confusion among the circuits, there can be no doubt that what the Court of Appeals did here bears no relation to any reasonable interpretation of that phrase.

Cases may arise where circumstances legitimately call into question the motivation of a claims administrator. And if the claimant can produce probative evidence that the decision was actually improperly motivated, it may be perfectly appropriate to consider those circumstances in determining whether the administrator has abused the discretion granted to him. *See Pari-Fasano v. Paul Revere*, 230 F.3d 415, 418-19 (1st Cir. 2000) (claimant bears the burden of producing evidence of improper motivation). But this is not such a case.

A so-called "inherent conflict," without more, cannot provide a basis upon which to depart from the abuse of

discretion standard. *See id.* And failing to defer to any arbitrarily selected piece of evidence solely because the court has deemed it more credible cannot provide the necessary evidence of improper motivation. If it could, then there would be no deferential standard notwithstanding *Firestone*.

The Court of Appeals' ruling with respect to conflict of interest was erroneous. This Court should reject it.

CONCLUSION

For the reasons stated above, this Court should reverse the ruling below.

Respectfully submitted,

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February 24, 2003